MEDICAL RECORD

Orders Manual: Ancillary Tests

PATIENT

Date:	NU/Clinic	Age	Sex ☐ M ☐ F	Is Patient Pregnant? ☐ Unknown ☐ Yes ☐ No Breast Feeding? ☐ Yes ☐ No	Patient's Phone Number: Diagnosis

Clinical Data-Special Precautions-Allergies

DIAGNOSTIC RADIOLOGY

EXAMINATIONS Circle View for Individual Tests — L=Left R=Right

☐	Chest PA LAT	☐	Thoracic Spine	☐	Foot L R	☐	Wrist L R
☐	Chest Fluoroscopy	☐	Met. Bone Sur.	☐	Ankle L R	☐	Elbow L R
☐	Skull	☐	Lumbar Spine	☐	Knee L R	☐	Shoulder L R
☐	Sinuses	☐	Abdomen	☐	Hip L R	Other	
☐	Mastoids	☐	Pelvis	☐	Femur L R		
☐	Sella Turcica	☐	Humerus L R	☐	Tibia/Fibula L R		
☐	Cervical Spine	☐	Forearm L R	☐	Hand L R		

EXAMINATIONS REQUIRING PREPARATION Advance Scheduling: Ext 7610

☐	Gallbladder	☐	Upper GI	☐	Barium Enema	☐	Lymphangiogram
☐	IVP	☐	Barium Swallow	☐	Mammogram	☐	Myelogram

Indications for X-Ray

Previous X-Rays at NIH?
☐ Yes ☐ No
☐ Check if Previous Films Needed for Next OPD Visit

Have X-Rays Been Scheduled?
☐ Yes, Give Dates _____
☐ No, Please Schedule for (Dates): _____

ULTRASONOGRAPHY Advance Scheduling: Ext 3380 • = Advance Preparation

UPPER ABDOMEN		PELVIS		SOFT TISSUES, EXTREM.		PATHOLOGY (✓ ONE)	
•	Abdominal Wall	•	Bladder	☐	Popliteal L R	☐	Congenital
•	Aorta	•	Lymph Nodes	Other		☐	Inflammatory
•	Bile Ducts	•	Ovary L R			☐	Neoplastic
•	Gall Bladder	•	Uterus			☐	Traumatic
•	Inf Vena Cava	•	Adnexal L R			☐	None
•	Liver	•	IUD Localization	**NECK**		**CONFIDENCE (✓ ONE)**	
•	Pancreas	•	Obstetrical	☐	Thyroid	☐	Known
•	Spleen	Other		Other		☐	Probable
Other						☐	Possible
						☐	Improbable

Indications for Ultrasonography (Circle or List as Many Choices as Necessary)

Mass, Solid, Fluid, Stone, Malformed, Viable
Enlargement, Diminution, Invasion, Perforation, Compression, Displacement, Obstruction
Acute, Chronic, Retarded, Accelerated
Single, Bilateral, Multiple, Absent
Right, Left, Superior, Inferior, Anterior, Posterior, Medial, Lateral
Proximal, Distal, Localized, Diffuse, Ectopic
Other:

Previous Ultrasound at NIH?
☐ Yes ☐ No

Have Tests Been Scheduled?
☐ Yes, Give Dates
☐ No, Please Schedule for: (Dates)

TOMOGRAPHY Advance Scheduling: ext 7610

☐	Full Chest	Indications
☐	Mediastinum	
☐	Sella Turcica	
☐	Internal Auditory Canals	
Other (specify)		

COMPUTERIZED AXIAL TOMOGRAPHY • = Advance Preparation: Ext 4972 •• = Advance Preparation: Ext 7700

☐	Cerebrum	•	Abdomen	☐ IL-2 Patient?
☐	Chest	••	Liver-EOE	☐ Contrast Required?
☐	Mediastinum	•	Pancreas	☐ Consent Signed?
☐	Bone Density		Pancreas	Have Tests Been Scheduled?
			Kidney	☐ YES, Give Dates: _____
			Pelvis	_____
			Other (specify)	

AUDIOLOGY

AUDIOLOGY Advance Scheduling: 6-5368

☐ Adult Exam ☐ Pediatric Exam, Age of Patient _____
☐ Initial Exam ☐ Follow up Exam ☐ Vestibular Testing
Reason for Referral: _____
History: _____
Medications: _____
Test Prescheduled for (date/time): _____

Date of next outpatient appointment: _____

_____
Physician's Printed Name Date Phone Number

(continued on back)

MEDICAL RECORD

Orders Manual: Ancillary Tests

MRI

MAGNETIC RESONANCE IMAGING (MRI) Advance Scheduling: Ext 0026

☐	Abdomen	☐	Gadolinium DTPA Contrast	☐	Parathyroid/Thyroid
☐	Adrenals	☐	Gadolinium DTPA Contrast	☐	Pelvis
☐	Breast		Agent Acoustic	☐	Pituitary/Sella
☐	Chest/Mediastinum	☐	Head/Neck	☐	Seizure
☐	CNS Disease	☐	Heart/Pericardium	☐	Skeletal
☐	Extremities	☐	Kidneys	☐	Spine
☐	Eye/Orbit	☐	Liver/Spleen	☐	Other:

Indications for MRI

NUCLEAR MEDICINE

NUCLEAR MEDICINE Advance Scheduling: Ext 0088 • = Advance Preparation

TESTS		BODY SURVEY		GENERAL INDICATIONS	
CNS		•	Bone Scan	☐	Initial Patient Evaluation
☐	Routine Brain	•	Gallium Scan	☐	Protocol
☐	Routine Brain and Blood Flow	☐	Whole Body Iodine Study	☐	Follow-up
☐	Cisternography	☐	Bone Marrow Study	☐	Neoplastic-Dx
ENDOCRINE (THYROID)		☐	Respiratory	☐	Infectious-Dx
☐	Thyroid Scan	☐	Ventilation-Perfusion (V/Q)	☐	Metabolic-Dx
☐	Thyroid Scan & Uptake — 24 hours	☐	NHLBI Protocol (V/Q/GA)	1. Patient Had Any X-Ray Contrast Media? (List)	
CVS (CARDIAC-RENAL)		☐	NHLBI Protocol (Gated Cardiac)		
☐	Renogram	☐	Other	2. Patient Had Thyroid Hormone? (List)	
GI-HEMATOLOGY					
•	Liver-Spleen			3. List Any Medication(s) Containing Iodine:	
•	Salivary (Parotid)				
				Previous Radionuclide Studies? (Where/When?)	

DENTAL

DENTAL Enter MIS order — Then call for Advance Scheduling: Ext 4371

INDICATION FOR CONSULTATION		EXTENT OF SERVICE DESIRED AND AUTHORIZED		RECOMMENDED PRECAUTIONS	
☐	Pre-Heart Surgery	☐	Consultation ONLY (NO Treatment)		
☐	Pre-Chemotherapy	☐	Consultation and Any Treatment with the Exception of (Specify)	☐	Blood and Bodily Fluids
☐	Pre-Head/Neck Radiation Therapy			☐	Drainage and Secretions
☐	Evaluation of Oral Effects or Therapy (Specify)			☐	Other
				☐	None
		☐	Required Pre-Dental Appointment Medication/Therapy Alterations (Specify)	Comments (Specify)	
☐	Evaluation of Other Oral Problem (Specify)			Please Select Whichever Applies Patient Is Hepatitis B_SAg	
		☐	NONE Required	☐ Positive ☐ Negative ☐ Unknown	

ECG

ELECTROCARDIOGRAM (ECG)

☐	ECG	☐	**INDICATIONS (✓ MORE THAN ONE IF NECESSARY)**
☐	ECG with Rhythm Strip	☐	Atherosclerotic Cardiovascular Disease
☐	Medications:	☐	Valvular Heart Disease
		☐	Congenital Heart Disease
		☐	Cardiomyopathy
☐	Prior ECG at NIH	☐	Hypertension
☐	Routine	☐	Pericardial Disease
☐	Urgent	☐	Preoperative
Has Test Been Scheduled? ☐ YES, Give Dates: _____ ☐ NO, Please Schedule for (Dates): _____		☐	Postoperative
		☐	Chest Pain/Palpitations/CHF
		☐	Other

ADMISSION/ TRAVEL VOUCHER REQUEST

ADMISSION/TRAVEL/VOUCHER REQUEST

☐ Inpatient/Admission Date	Date: From: To:	Guardian ☐ YES ☐ NO
Voucher Date From: To:	Travel Date	
Diagnosis	Attending Physician's Name:	

LIP Signature	LIP Name (printed)	Date